



New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Marriage and Family Therapy Examiners
Alcohol and Drug Counselor Committee
124 Halsey Street, 6th Floor, P.O. Box 45040
Newark, New Jersey 07101
(973) 504-6582

PROPOSED PLAN OF SUPERVISION FOR C.A.D.C./L.C.A.D.C. INTERNSHIP

Has the INTERN read the regulations re: Alcohol and Drug Counselor Internships? ☐ Yes ☐ No

Has the SUPERVISOR read the regulations re: the clinical supervision of Alcohol and Drug Counselor Interns? ☐ Yes ☐ No

Date: _____

Intern Information

Name: _____
Last name First name Middle initial

Mailing address: _____
Street or P.O. Box City State ZIP code

Home telephone number: _____ Cellular telephone number: _____
(include area code) (include area code)

1. How many of the 270 core-training hours in Addiction Studies has the INTERN already completed? _____ of the 270.
(See schedule B of the C.A.D.C./L.C.A.D.C. application.)
2. Does the INTERN hold a degree from a college or university? ☐ Yes ☐ No
(Include this information in the attached resume.)
3. Does the INTERN hold another clinical license at this time, making him/her a CREDENTIALLED INTERN? ☐ Yes ☐ No
(Include this information in the attached resume.)

Proposed Internship/Worksite setting: (check one)

☐ Division of Addiction Services Licensed Agency ☐ Other Agency ☐ Private/Group Practice ☐ Other

Name of Work/Internship Setting: _____

Address of Worksite: _____
Street or P.O. Box City State ZIP code

Telephone number: _____ Tax status: ☐ for-profit ☐ not-for-profit
(include area code)

Proposed Supervisor

Name of Supervisor: _____
(Attach supervisor's resume.) Last name First name Middle initial

Address of Supervisor: _____
Street or P.O. Box City State ZIP code

Telephone number: _____ Is supervisor C.C.S. Credentialed? ☐ Yes ☐ No
(include area code)

Licensure of proposed supervisor: (Check all that apply.)

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> L.C.A.D.C. | <input type="checkbox"/> L.P.C. | <input type="checkbox"/> L.M.F.T. |
| <input type="checkbox"/> L.R.C. | <input type="checkbox"/> L.C.S.W. | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Physician A.S.A.M./A.B.A.M. Certified? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Psychiatrist A.S.A.M./A.B.A.M. Certified? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Psychiatrist, A.P.A. added credentials in addictions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Has the Proposed Supervisor ever had a license restriction imposed which prohibited the supervision of others? ☐ Yes ☐ No

N.J. License Number(s) _____ for _____ License
of the Supervisor

_____ for _____ License
_____ for _____ License

(If the internship will be in another state, supervisors should list their New Jersey license number as well as the number of the license held in the other state.)

Modalities of Supervision Planned: (Check all that apply.)

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Live in the Room | <input type="checkbox"/> Case Reviews | <input type="checkbox"/> Record Reviews | <input type="checkbox"/> Audio Tape/Reviews |
| <input type="checkbox"/> Video/Closed Circuit | <input type="checkbox"/> Verbatims | <input type="checkbox"/> 2-Way Mirror Observation | <input type="checkbox"/> Other |

Supervisor's Signature Date Intern's Signature

Attach the following to this application and return it to:

Alcohol and Drug Counselor Committee
P.O. Box 45040
Newark, New Jersey 07101

1. The resume of the INTERN (include formal academic information if available)
2. The resume of the SUPERVISOR (include academic, licensure and certification information)
3. A brochure (or description) of the agency/program or practice setting
4. A copy of the written Internship Agreement between the Intern and the Supervisor. (Include a copy of Disclosure 6.2(c).)